By email: HPC-Testimony@state.ma.us

September 2, 2016

Mr. David Seltz
Executive Director
The Commonwealth of Massachusetts
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Mr. Seltz:

On behalf of Arbour Health System (AHS), attached is the requested written testimony in response to questions of the Health Policy Commission (HPC). We are submitting this testimony electronically in pdf and Word format to HPC-Testimony@state.ma.us as requested including responses to areas of inquiry from the Health Policy Commission and from the Office of the Attorney General. For your reference, Arbour Health System is comprised of Arbour Hospital, Arbour-Fuller Hospital, Arbour-HRI Hospital, Westwood Lodge, Pembroke Hospital, Arbour Counseling Services, and Arbour SeniorCare.

Should you have any questions regarding this submission, please contact Judith Merel, Regional Director, Business Development, AHS, at 617-390-1224 or at judy.merel@uhsinc.com. As Massachusetts Group Director, I am legally authorized and empowered to represent the organizations under its umbrella for the purpose of this testimony, and the testimony has been signed under the pains and penalties of perjury.

Sincerely,

Dania O'Connor, MSSW
Group Director, Massachusetts

1. **Strategies to Address Health Care Cost Growth.**
Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.
    a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)
    Most Arbour Health System (AHS) hospitals have contained growth expense below the 3.6% benchmark while managing improvements to clinical programming and facilities/environment of care. The expense growth rate has in part related to beds/units being capped at times during 2016 due to workforce (MDs/RNs/Mental Health Associates) shortages.

    Three areas of concern for meeting the benchmark in the future include those related to staff recruitment and retention (as compensation adjustments are made to attract and retain psychiatrists and psychiatric nurses who are in high demand in Massachusetts and other parts of the country), investments in information technology, and cost increases associated with higher patient acuity and medical co-morbidities including, but not limited to, pharmaceutical costs.

    b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)
    One of the top changes in regulation that would support hospitals in expense management is the 24/7 on-site physician coverage regulation which requires all DMH Licensed hospitals to have a physician on site at all times. Massachusetts is one of only three states that have such a requirement and this also goes beyond The Joint Commission and Centers for Medicare and Medicaid Services requirements. There is no evidence that the quality of care is diminished in states without this requirement and without this mandate would allow hospitals to better manage resources and expenses. There has been movement on allowing greater use of telemedicine as a cost-effective, efficient alternative. As well, there are other uses of telemedicine/telepsychiatry that could be implemented including for outpatient services and acute care hospital consultation. It is imperative that, with appropriate standards developed for its use, payers ensure coverage/funding for telepsychiatry services.

    It is also recommended that inconsistent performance specifications and requirements across payers be addressed and reviewed -- micromanagement by managed care including utilization management, inability to use physician extenders including psychiatric nurse practitioners or clinical nurse specialists in certain appropriate settings or under supervision of psychiatrist that add to cost of care and do not impact quality. Greater use of advanced practice nurses could be enable admission/discharge of patients in coordination with the

attending physician, certification of restraints, and availability for daily patient visits under supervision of a psychiatrist.

As well, to support the goal of meeting the health care cost growth benchmark, it is imperative to assure availability of and access to levels of care that are appropriate for patients as part of their treatment plan including community-based services, acute residential programs, and eliminate services/access barriers related to those with state-agency involvement including DMH, DYS, and DCF. There are important issues related to certain regulations that impede ability to efficiently care for patients or move patients to the appropriate level of care or service site. Reform of the Rogers process is needed to allow hospitals ability to provide necessary medications on a timely basis for needed, appropriate treatment. State agencies need to develop a facilitated process for the administration of antipsychotic medications for hospitalized youth including those in custody of DCF. Also, improving access to state hospitalization beds will reduce number of "stuck" patients in EDs and the number of patients in high cost inpatient settings.

2. Strategies to Address Pharmaceutical Spending.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Currently Implementing

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Currently Implementing

iv. Establishing internal formularies for prescribing of high-cost drugs

Currently Implementing

v. Implementing programs or strategies to improve medication adherence/compliance

Plans to Implement in the Next 12 Months

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Does NOT Plan to Implement in the Next 12 Months

3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

Given that Arbour Health System (AHS) is comprised of freestanding psychiatric hospitals and outpatient clinics, provision of behavioral health care is the primary mission of the organization. All hospitals are licensed by the Department of Mental Health and several have licensure by the Department of Public Health Bureau of Substance Abuse Services (BSAS). Outpatient clinics are licensed by the Department of Public Health, most for both mental health and addictions. Over the next year, additional AHS organizations will seek BSAS approval. AHS hospitals and outpatient counseling centers have developed expertise in treatment of "dual diagnoses." Given the current opioid crisis in the Commonwealth of Massachusetts and with a significant majority of patients having co-occurring psychiatric and addictions disorders, it is imperative that facilities address both issues simultaneously to reduce recidivism, improve outcomes and contain overall long-term cost growth. The hospitals and outpatients centers also address patients with co-morbid medical conditions by assessing medical history/current conditions, having on-site primary care clinicians, integrating with area acute care facilities for behavioral health consultation and referral, and coordinating with primary care clinicians.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

Given that Arbour Health System (AHS) is comprised of freestanding psychiatric hospitals and outpatient clinics, provision of behavioral health care is the primary mission of the organization. In follow-up to question above, having separate licensing agencies (DMH and DPH) for mental health and primary addictions programs with different standards and and/or coordination of licensing/reporting can be a barrier.

As well, with the implementation of Chapter 258, there were positive changes to address patients with primary addictions disorders – those who are admitted with a primary psychiatric diagnosis and co-occurring substance use do not have the same allowances including elimination of prior authorization and provision of additional days before initial utilization review. For those who are dually diagnosed, there continues to be less recognition that both illnesses need to be addressed simultaneously or will lead to a "revolving door" for those who have not been afforded enough time to address both illnesses.

Again, recruitment/availability of staff including psychiatrists is a barrier to care provision and may impede enhancing or integrating behavioral health.

Psychiatrists not currently practicing in Massachusetts at times wait significant lengths of time to get licensure through the state's Board of Registration of Medicine. As noted in another question, use of telepsychiatry would potentially enhance integration of behavioral, addictions, and medical care.

Further, certain managed care plans do not authorize/reimburse for clients who are seeing a clinician and psychiatrist on the same day for outpatient services – this is a barrier for patients who need therapy and psychopharmacological services. Access and compliance would be improved if two outpatient behavioral health visits per day were allowed.

4. **Strategies to Recognize and Address Social Determinants of Health.**

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

There are no specific, focused strategies that the organization is engaging in at this time to address the social determinants of health for patients. On intake, inpatient, partial hospitalization, outpatient and community-based staff assess patients for social, economic and physical conditions which are important drivers of health outcomes. Staff addresses issues including, but not limited to, housing, domestic violence, employment, and food insecurity. As part of the assessment and ongoing treatment planning, there is a focus on understanding patients' needs and what will assist in improving their compliance with care. Physicians, social workers, etc. assess patients' needs relative to making referrals to and engaging them with agencies that can provide social services support.

The availability and use of community-based outreach services such as Community Support Programs (CSP) are important resources that provide assistance post-discharge for clients accessing needed services. While no formal strategies are in place tied to understanding social determinants of health, the system has a longstanding history of caring for those with socioeconomic and other cultural concerns and, as a result, AHS has developed strategies to assist those who may be homeless, unemployed or need financial support. As examples, the development and availability of supervised dormitories in connection to PHP programs accommodate patients who have transportation concerns and housing issues which may lead them to prematurely drop out of the treatment program.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)
While AHS patients are assessed for socioeconomic concerns in addition to medical issues, there are a number of barriers related to addressing the social determinants of health to improve outcomes. For AHS, patients are referred from all communities in Massachusetts – discharge planning and care coordination can be made more difficult by not having adequate information on local resources or having available time within short, acute hospitalizations to address/coordinate all issues. Managed care plans may have intensive care coordinators or outreach staff but it may be unclear how they assist in social or economic issues as part of a care plan to improve outcomes. As noted in another question, use of programs such as CSP aide post-discharge compliance or access to services. There are specific issues/barriers hospital case managers encounter including, but not limited to, wait lists for programs, shelters not allowing patients back to their programs, patients who are homeless and note difficulty with place for disability payments and other mailings to be sent, food pantries with limited hours that make access difficult, lack of available transportation to reach primary care clinicians, food pantries, employment agencies, etc. Barriers also include patients having funds for copayments for medications or safe places to store medications. As well, certain patients decline offered aftercare services and, while appointments made, no show rates can be high. Hospitals are not compensated for services such as navigators/care coordinators to assist patients following discharge and ensure ongoing compliance including with medication management.

AHS clinicians including for inpatient, PHP, outpatient and community services do routinely provide information on services that will address social and economic issues – these include but are not limited to area job openings, lists of area food pantries, and other resource information. Updated, centralized databases by geographic region to support staff in identifying resources would be beneficial to assist in addressing the social determinants of care.

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.
Arbour Health System is a vertically, integrated behavioral health system with community-based, outpatient, intensive outpatient, partial hospitalization, acute residential and inpatient programs. Providers within the organization are made aware of services across the system including by geography, admission criteria, specialty (GLBTQ, developmental disabilities, etc.) AHS has been shown to be a low cost provider by certain external data including as developed on behalf of

managed care organizations, however, staff most often make determinations on referrals based upon patient need/preference, ability to access services/geography, insurance coverage/ approval, referral relationships, etc. There has not been significant focus on encouraging providers within our organization to access "high-value" specialty or other care as this information is not transparent or fully vetted as to its accuracy based upon factors such as patient acuity, case mix, satisfaction, outcomes, etc.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

   i. If yes, please describe what information is included.
   Not applicable

   ii. If no, why not?
   Not applicable

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

   i. If yes, please describe what information is included.
   Not applicable

   ii. If no, why not?
   Not applicable

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
No

   i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.
   Not applicable

   ii. If no, why not?
   Not applicable

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)
Arbour Health System has limited alternative payment methods (APMs) but would be interested in increasing their adoption with appropriate information/methodology. While AHS is interested in pursuing the adoption of APM methods, the organization has not been approached by specific payors or other providers to participate in alternative payment methods other than capitation contracts for a limited population by one managed care plan. APMs that have been discussed need to address transparency of information including case mix, acuity, coordination of care, outlier management, etc. The infrastructure investments and changes to the care model required to enable success for behavioral health under APM methods include EHR/IT upgrades, recognition of additional costs of care related to care coordination/navigators, etc. AHS, as a low-cost, efficient provider of care, will be pursuing arrangements with ACOs to provide behavioral health services across the system's vertically integrated services. Strategies include outreach/discussion with payers and providers who are in position to respond to or develop ACO initiatives and presentation of information on the "value" of system services.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)
For Arbour Health System, the top barriers to the organization's increased adoption of APMS include not being part of a physician organization and/or acute care systems that may be gaining APM agreements. While these organizations will need to access efficient, high quality behavioral health services, they may look within their own organization/system to access services and these may be at higher cost with similar outcomes as AHS. As was noted, the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers. Other barriers include operational issues including, IT structure, staffing enhancement (care management), and provision of information to adequately assess service delivery cost and financial risk, especially related to high acuity patients and outliers.

c. Are behavioral health services included in your APM contracts with payers?
No
    i. If no, why not?
    Not applicable.

7. Strategies to Improve Quality Reporting.

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that

the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.
The lack of alignment in quality reporting does not pose a significant challenge for the organization at this time. Different metrics identified and how they are used does create additional staff effort/expense and do not result in meaningful comparisons either for internal or external purposes. There are some quality measures such as reporting of sentinel events or restraints which differ between DMH and The Joint Commission which does result in significant resources to collect/evaluate. The lack of alignment is not specific to different health plans but also applies to state licensing and national accreditation agencies.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).
There should be alignment in the number, type and specifications of quality metrics that reflect outcomes for behavioral health. In the case of behavioral health, metrics or "progress reports" are often identified for 7 and 30 day readmission rates, follow-up rates with aftercare providers, peer review rates, spend per episode, length of stay, case mix adjusted length of stay, etc. This information is not appropriately or consistently case mix adjusted in most instances. Certain payers produce monthly reports which are reviewed with senior leadership, however, they reflect different reporting periods and may also be applied against internal benchmarks which are note well defined or do not provide appropriate comparisons. Strategies to promote alignment require external organizations such as MassHealth and others to review quality measures collected and incorporate feedback from providers including on reporting frequency and format as well as how information is used. Payers, given that most are part of national companies with standardized systems, provide quality information to hospitals and will not be in a position to align with other payers for consistency. Hospitals often use different tools to report patient experience and these will be difficult to standardize.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.
No optional supplemental information.

Exhibit C: AGO Questions for Written Testimony

1. Please submit a summary table showing for each year 2012 to 2015 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.
   See attached AGO Provider Exhibit 1.

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.
      Arbour Health System hospitals had systems in place prior to the implementation of Chapter 224 related to the consumer inquiries regarding price/charges for services within the system. There has been no change in these processes since the implementation of Chapter 224. Consumers can inquire about the price of services through the applicable Business Office.

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.
      On consumer inquiries or requests, hospitals respond within 24 business hours. There is no formal monitoring or analysis that is being conducted concerning the timeliness of responses – information should be highly accurate as being communicated by the facility Business Office Manager or designee. Given that the charge or reimbursement is on a per diem basis, if a patient is inquiring about total cost of stay it must be estimated based upon am average length of stay -- each patient receives individualized treatment and there are variable lengths of stay.

   c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?
      There are no barriers that have been encountered in timely response to consumer inquiries for price information. Accurate response, as noted above, is complicated by patient presentation/individualized treatment plans and pre-identifying length of stay/service for total price of service especially for inpatient admissions. As noted in question above, information is provided on a per diem/service basis and estimated based upon expected/authorized length of stay/course of treatment.